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ORIGINAL ARTICLES.

Aphasia.

BY P. DAUGHERTY, M.D., JUNCTION CITY, KAS.

Read at the meeting of the Golden Belt Medical Society, Solomon, Kas., January 7, 1897.

Mr. President and Gentlemen of the Golden Belt Medical Society: When we think of the progress made in medicine and surgery during the present century we are amazed. Can we form any conception of what the twentiety century has in store for us? Had the physician or surgeon of one hundred years ago, or even sixty years ago, met with a case of injury of the spinal cord, such as that described by Brown-Sequard in 1865, he would have been perplexed, utterly unable to locate the lesion from the symptoms present. But should a case of this kind be brought to any of you today, and you should find, on examination, complete motor paralysis on the right side of the body from the neck down, with extreme hyperæsthesia on same side, not only to touch, but to heat and cold, tickling and painful impressions of every kind, with increase of temperature and on the opposite side of the body find all of these conditions completely reversed. The power of voluntary motion here is complete. The muscular sense, or sense of resistance is intact, but the sensory nerves that are hyperæsthetic on the paralysed side, are dead on this side, you would have no hesitancy in diagnosing this case as one of injury or disease involving the entire lateral half of the spinal cord in the neck. Brown-Sequard produced this train of symptoms in animals by a division of the entire lateral half of the cord in the neck, and he also saw cases in the human subject where the diagnosis was verified by the post mortem. If little was known of the minute anatomy and physiology of the various columns of the spinal cord during the first half of this century, much less was known of the functions of the various parts of the brain. Lesions are now localized in the brain by the parts of the body affected with symptoms. The convolutions of the brain, their minute anatomy and functions were made a careful study by Hughlings Jackson, who was one of the pioneers in cerebral localizations. He based his observations on clinical medicine. Broca, another pioneer, based his observations upon morbid anatomy. Later came Fritsch and Hitzig, Ferrier and Harsley, basing their observations upon experimental investigations, vivisection playing an important part. Today we know pretty well the cortical centers of all the movements of the body, as well as those of the special senses. These senses are bound together by commissural fibers, anatomical integrity of which is necessary to their normal physiological action. Aphasia is the loss of articulate language, not from lesions of the peripheral organs or nerves, but from lesions of the cortical centers concerned. Charcot divides the center for articulate language, which is situated in the base of the third frontal convolution of the left hemisphere, principally into four sub-centers. A visual center for words, an auditory center for words, and a motor center for articulate language, and a motor center for written language. The different forms of aphasia depends upon lesions of these centers, or of their commissural fibers, or of the emissive chanels between any one of these centers and the moter centers in the corresponding corpus striatum. Damage to the auditory

word center results in word deafness, in which spoken words are not understood. Damage to the visual word center results in word blindness, in which written or printed words are not understood. Damage to the motor center for articulate language results in aphemia, or inability to express thoughts by articulate language. Damage to the motor center for written language produces agraphio, or inability to express ideas in writing. A. Carlton Bastian in his masterly work, "The Brain as an Organ of Mind," reports a number of cases of damage to one or more of these centers without the others suffering.

The following case which is under my care well illustrates damage to three of these centers, while the fourth remains normal: L. C., male, age 74 years, of English parentage, the oldest of nine children, all living. Family history negative. Came to this country in 1850. A farmer by trade; was never married, and never had venereal disease of any kind. Always enjoyed good health until three years ago. Since then he has suffered from vertigo by spells, and a general running down of the system He is a man of extensive reading, and intellectually much above the average. On October 24 last I was called to see him. The day before my visit he was sitting in the house reading, apparently in his usual health. The lady of the house noticed him drop his book in his lap and attempt to replace his glasses in the case, which he succeeded in doing after a number of ineffectual attempts. She spoke to him, but he made no answer. He got up and staggered to the stairway; the lady went to his assistance and helped him upstairs to bed. Next morning he came down walking all right, but could only say "yes" or "no," and could neither read nor write. He seemed to understand everything that was said to him, but could not answer. I saw him that afternoon. He seemed pleased to see me, extended his hand, and his face wore a wreath of smiles. I soon discovered that he understood perfectly everything I said to him, but he could only answer "yes" or "no" in a hesitating manner. I asked him if his head hurt? He answered "yes—no," and shook his head. He tried to tell me something by signs, but I failed to understand him. I then asked him if his head felt full or heavy, and he said "yes," and nodded his head. He would promptly perform any movements that I asked him to. There was no paralysis of motion that I could discover; not even a paresis in any part of the body. He was unable to read or write, and did not recognize his own name when written. November 7 he called at my office, looking well. He was eating and sleeping well at this time. His speech had improved some. He could get off part of a sentence correctly and then make a bad break, then check himself by saying "no—not." I tested his reading, but he could not read a word. I asked him if he could see the letters and words. He answered "yes." Can't you tell what they are? "No." A week after this he called on me again. His speech was still improving. He could then repeat after me words and short sentences; but the written or printed page awakened no response in his visual word center. I saw him last but a few days ago and he carries on a conversation with but little hesitancy. He will sometimes get the wrong word and stop and correct himself, and again fail to catch the word he wishes to use and say, "I can't think of it." He tells me that he cannot read to get any sense out of it, and is still unable to write. He has no recollection of the attack, and thinks his mind must have been a blank for a time, but knew everything the next day and has continued to do so since.

This case, to the physician of even fifty years ago would have been a sealed book. However eminent or learned he may have been in the profession he would have failed to locate the lesions from the symptoms present. Today the diagnosis is easy. We know that in this case the auditory center for words is not damaged, for he perfectly understands everything that is said to him. We know that the motor center for articulate language is damaged; or that the transcortical motor path between the perceptive center located in the first temporal convolution, and the cortical center for vocal utter-

ance, located in the base of the third frontal convolution, is damaged. Damage to those commissural fibers produces what is known as amnesic aphasia. We know that in this case there is damage to the motor center for written language, or to the commissural fibers between this center and the motor centers in the corresponding corpus striatum. We know the visual center for words is damaged, for he suffers from word blindness. Alexia may be produced by damage to the commissural fibers for transmitting impulses from the visual word centers to the centers for word memories in the first temporal convolution in the left hemisphere.

It is a remarkable fact that these centers are all situated in the left hemisphere. When you find them on the right side the person is left handed. All these centers are nourished by the sylvian artery and its branches. These centers may be damaged by direct violence, such as fracture of the skull, or concussion of the brain, or from embolism, or from blood clot.

I think the damage in this case was produced by the rupture of a miliary aneurism on one of the branches of the sylvian artery and the prognosis is favorable. I believe there is an atheromatous condition of the arteries of the brain in this case, and that he will die ultimately from apoplexy.

Appendicitis.

BY E. W. HAWTHORNE, M.D., NEW CAMBRIA, KAS.

Read at the meeting of the Golden Belt Medical Society' Solomon, Kas., January 7, 1897.

In selecting the subject of "Appendicitis" I do so knowing the urgent need of a more definite understanding of the morbid condition that confronts us. I do not deem it necessary to go over the long list of symptoms, diagnosis, prognosis, and a general history of such cases as we find them in our text-books, for we have all read them over time and again. But, instead, I wish to report a few cases in a brief, concise manner, and, as it were, make a clinic of each case; also give treatment of each with results, hoping by so doing I may be able to add some new thought and evoke from some of my more able brothers some worthy criticism that may be of lasting benefit, not only to myself but to all present.

Case A.—Mr. A., age 45, farmer. Had always enjoyed good health; was taken with pain in right ileac region, bowels confined. Examination: hard mass in right ileac region; the seat of greatest pain was half way between superior spine of ileum and umbilicus; slight fever and some vomiting. By mild laxatives and enemas the bowels were cleaned out and he improved for a time, the tumor partly disappearing. A few weeks later there was a recurrence of the symptoms and under similar treatment he improved again, but recovery was not so complete as from first attack. For the next three months there were alternating periods of improvement and bad spells, but the tumor was continuously enlarging. At this period the patient was brought to the hospital for operation. I am indebted to Dr. Duncanon for the history of the case up to this time. The operation was performed by making a circular cut over the tumor; the tumor was found to be a mass of fibrous tissue involving wall of the intestine, two or three inches of the lower end of ileum, ileocæcal valve, and four inches of the ascending colon, the appendix being obliterated, making a tumefied mass irregular in shape, three and one-half to four inches thick by six or eight in length. We deemed it not advisable to try to remove the mass, so we replaced it and closed up the wound. The patient died the fourth day of exhaustion.

Case B.—Freddie W., age 9 years, was an ordinarily strong boy; complained of pain in bowels for two or three days. His mother gave him on May 3 teaspoonful of sulphur; got no results, so she gave him sulphate magnesia, from which she got free catharsis, but the abdominal distress grew worse. So on the 5th (two days later) he was brought to my office. Examination showed hard, nodular mass in right ileac region, apparently at lower end of ascending colon, very sensitive to the touch, and painful by any jolting. The mass was about the size of a

man's fist. Temperature 100½°. He had slept but little for two nights. I gave Hg_2Cl, ¼-grain doses, every three hours; ¼ grain morphine every three hours. He rested but little during next eighteen hours. Called and found temperature 101⅛, some peritoneal tenderness and tympanitic. Gave enema, warm water and turpentine, which gave some relief. Applied locally lard, turpentine and camphor, hot, and kept it on continuously, changing often. I asked for counsel in the case, and Dr. Dewees, of Salina, was called. He confirmed my diagnosis, and the same line of treatment was continued for four days, excepting that only enough of the opiate was used to give him rest. The fourth day there was a general running off from the bowels and the tumor grew decidedly smaller. Tenderness and swelling gradually disappeared and convalescence set in. I know what you have all said in your minds already that this was a simple case of impaction. Maybe so; but remember there was a free saline catharsis secured before I saw the case, and was yet going on when the case came to me, and I had good reason to believe that all fecal matter had been removed; and further, by my enemas I got no fecal matter, hence I had reason to think the tumor was not fecal. Under nutritious liquid diet and tonics he made a good recovery, but has since had several milder attacks.

Case C.—Mrs. A., age 35 years, mother of two children, one 12 other 16 years old; had always enjoyed good health up to July 18, 1896, when she was seized with severe pain in bowels which lasted three days, or until a free catharsis was secured, after which she was greatly relieved, yet not entirely so, and she was not just quite well after that (she had no medical attendant at this time). On October 4, 1896, I was called in night to see her. found her in great distress; bowels acting fairly well. She had not slept for two nights; slight elevation of temperature. The pain was not in the ileac region, but just above umbilicus. Examination showed hard nodular mass in right ileac region about midway between umbilicus and spine of ileum; the mass was movable, elastic, moderately painful to touch. My diagnosis was old saculated impaction without stoppage. For the pain I gave morphine hypodermically until rest and sleep was secured, followed up with Hg_2Cl in broken doses up to 8 grains. Then gave emulsion oleum recina until a thorough and complete catharsis was secured. Locally I used hot lard, camphor and turpentine, changed often. The catharsis greatly reduced the size of the tumor and gave great relief, but still the tumor was perceptible but less painful. She made a nice recovery for two weeks and was able to do her housework. On October 17 she came to my office. a distance of three miles. Examination showed some enlargment, but tumor was soft and yielding and slightly painful upon pressure. I kept her now on turpentine emulsion, and to keep bowels acting well cascara sagrada; gave her tonics; her appetite was good most of the time. After this visit to my office she had a severer spell that lasted three days, but gradually subsided. One week later she was able to visit my office again, and she again suffered three or four days from the jolting. Riding or any jolting would bring on a new attack. The tumor alternated between periods of improvement with shrinkage in size, less pain and tenderness, and then enlargment and pain; but the tendency was to a continued increase in size. I now, November 8, 1896, asked counsel in the case and Dr. S. B. Mayfield, of Salina, came out to see the case with me. His diagnosis was appendicitis with a pus cavity, and advised early operation. She was taken to Salina Sanitarium and on November 16 operation was performed—a seven inch straight cut made in right ileac region over tumor. We found a hard fibrous mass three and a half inches by six or eight long, involving the lower two or three inches of the ileum, the ileacæcal valve, and the four or five inches of the ascending colon. The appendix was either adherent or so much absorbed as to be totally obliterated. There was no ulceration or pus. The tumor was adherent to all the surrounding structures and other organs to such an extent as to contraindicate its removal. We replaced it, closed the

wound with silk, patient rallied, and in eight days stitches were removed and had good union. Up to this time patient had but little pain, but now, after eight or nine days, there appeared to be a recurrence of the same trouble, and she again suffered pain and flatulence, the distress growing worse from time to time. It required large doses of morphine to give her any rest. She died three weeks after operation from marasmus.

Now, gentlemen, I have reported three cases of appendicitis, but neither of them have proven to be appendicitis. One of the objects I have in writing this paper is to demonstrate the fact that not all people who have pain and swelling in right ileac region are afflicted with appendicitis, and the surgical cases of appendicitis are few and far between. Notwithstanding, they do exist, and should be treated as such when met.

Cases A and C are very closely related as to the morbid condition that existed, but still there is quite a difference in symptoms. Case A was examined by several of the best Kansas City surgeons, among them Dr. Halley and Dr. Willis P. King, and was diagnosed by all as appendicitis and an immediate operation advised.

Oil as a Hair Tonic.

A common cause of alopecia is, the scalp is washed too often and thus lacks oil. Many races oil the hair, and such are seldom bald. Some animals also, as, for example, birds, which possess neither seborrheal nor sebaceous glands, have a gland which secretes an oily substance which protects the feathers from the action of the water. The product of sebaceous glands is remarkably rich in fat, and possesses a notably small amount of water. The falling of a certain number of hairs is a physiological phenomenon. I am of the opinion that the application of oil would be beneficial to most persons, and it is suggested that the rubbing into the scalp of a pomade or other fatty substance be made part of the daily toilet, the pomade to carry with it some antiseptic substance.

Catching Cold.

London Medical Press.

The "cold spots" meaning thereby the surface areas peculiarly susceptible to cold, are principally the nape of the neck and the lower part of the back of the head, the front of the abdomen and the shins. The acute discomfort and the sense of impending disaster which results from the steady play of a current of cold air upon the neck from behind are well known. The necessity of keeping the abdomen warmly clad is also generally recognized, though perhaps not as generally carried into practice. Curiously enough, few people are conscious of the danger they run by exposing the usually inadequately protected shins to currents of cold air. This is usually the way in which colds are caught on omnibuses. When driving one takes care to cover the legs with a rug or waterproof, but on the more democratic conveyance rugs are not often available, and the reckless passenger by-and-by awakens to the fact that the iron has entered into his soul—in other words, that he has "caught cold." People who wear stockings, such as Highlanders, golfers and cyclists, invariably take the precaution of turning the thick woolen material down over the shins, the better to protect them against loss of heat, though, incidentally the artificial embellishment of the calves may be altogether foreign to the maneuver. This is an instance of how all things work together for good. It does not, of course, follow, because certain areas are peculiarly susceptible to cold, that a chill may not be conveyed to the nervous system from other points. Prolonged sitting on a stone, or even on the damp grass, is well known to be a fertile source of disease; and wet cold feet are also, with reason, credited with paving the way to an early grave.

DR. MARKS, of Valley Falls, is a member of the House and an enthusiastic worker for medical legislation.

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Topeka, Kansas, Saturday, Jan. 9, 1897.

IT is a reasonable conclusion from the present advanced knowledge of diseases, that all diseases are curable and that sometime the proper means will be discovered. We have mode but little advancement in the treatment of tuberculosis and probably less in the treatment of malignant tumors. Careful investigation of these troubles has taught us much of their pathology, but has given little clue as to the means for cure. Tuberculosis is properly classed as a curable disease, because we have post mortem evidence that it has been cured. There can be no question but malignant growths have been removed by one or another means without a return. These are points of evidence of the curability, but have not so far led to that interpretation of nature's forces necessary to a proper understanding of the remedy. Centuries have been spent in the attempt to solve this problem. Thousands of experiments have been made and as many proposed cures have been advanced, tried and discarded. This easily accounts for the present suspicion with which all such proposed cures are met and lack of interest in the discussion of these subjects. It is hardly likely that the cure of these troubles will be the result of a single discovery, but the combined elements of a large number of investigations. Deductions from a compiled report of all the theories of the cure of cancer or tuberculosis would doubtless afford a more rational basis of treatment than any of the more recent theories taken alone. The aversion to the subject by the profession does not tend to aid the successful issue, but neither does it retard the effort of those who have made it their life work. A united effort on the part of the profession and a comparison of notes without concealment, and honest discussion of the merits of each, will we believe bring about a better solution of the problem.

THE next meeting of the Kansas Medical Society will be held in May next and the secretaries are already at work on the program. Those who desire to furnish papers for the meeting should address the secretary of the section in which he desires it to appear. The following are the secretaries of the various sections:

Ophthalmology and Laryngology—Dr. R. S. Magee, Topeka.

Surgery—Dr. W. F. Sawhill, Concordia.

Gynecology and Obstetrics—Dr. O. J. Furst, Peabody.

General Medicine—Dr. J. W. Porter, Litchfield.

NEXT Tuesday the new Legislature will be in session and the interests of every regular practitioner in Kansas will be under consideration. Several bills for the regulation of medical practice will be introduced, and the support of a number of populists is already promised. With the united efforts

of the profession and the influence which they can bring to bear upon the members, there is every reason to believe that their interests will not again be slighted. A great many physicians in the State have already tendered their services and support. Let's hear from more.

DR. DUMBAULD, of Waverly, Kas., is in the city at the legislative pie counter. The doctor is a promising candidate for a berth at the State Penitentiary.

DR. G. A. WALL, formerly of Topeka and recording secretary of the Kansas Medical Society, has located permanently in Albuquerque, New Mexico.

MISCELLANEOUS.

Western Surgical and Gynecological Association.

Address of President Dr. T. J. Beatie: "I am extremely grateful for being president of this society. This society is the outgrowth of the society of five years ago. It is only necessary to look back a few years to satifsy us that a great change has taken place." The president then spoke of the increase of educational advantages in this country and thinks that in time people will come to the West to obtain their education. "These societies are for our benefit and we should take pains to attend every one." Before one should make a specialty, he should practice ten or twelve years. Specialists are becoming so numerous that in years to come the general practitioner will be required to practice only on measles and fevers. When Sims established the New York Hospital the people did not pay much attention to him, and now the world of physicians are greatly indebted to him.

By the growth of bacteriology it has been shown that many diseases are dependent on the growth of certain germs. Abdominal operations have now become very prominent and we are not afraid to go in for tumors of any size. It has been determined beyond a doubt that the abdomen can be opened without any danger to the patient. Diseases and injuries of the cavities are becoming more extensive.

Vaginal Hysterectomy: Joseph Eastman, M.D., Indianapolis—There are two subjects near my heart for the last two years: The subject of "Hysterectomy" and what people are doing in the Western part of this country. Ten years ago I published a work on abdominal surgery giving a general view of methods of abdominal operations. The field for vaginal hysterectomy is in cancer, pelvic inflammation, neurosis and end of menstrual period or menopause and dysmenorrhœa. Cancers are on the increase and are of local origin generally. A very early recognition of the disease is important. There is hemorrhage followed by thin watery discharge with odor. This is due to the progress of the disease, the putrefaction of the cancer. The time honored teaching that a woman having these symptoms is simply passing the menopause has passed. Pain is not a necessary symptom for cancers of the uterus. The time has come when any woman who has hemorrhage or any pain and trouble in the menstrual flow should be looked after. We find involvement of the glands connected with the uterus is usually present.

Objective signs must be added to the clinical history, there should be a microscopical examination of a piece of tissue from affected part. There must be an early diagnosis then thorough and definite operative procedures. Eight years ago I had no idea we would have vaginal hysterectomy so soon.

I think that we can come nearer dealing with adhesions of the omentum by abdominal sections than by vaginal hysterectomy. The admission of air through the abdominal cavity through the incision is deleterious to

the vermiform appendix. Vaginal hysterectomy for pelvic inflammation will I believe soon come to be of no use.

We are indebted to Dr. Jacobs, the great operator, yet many men in the West can give him points in vaginal hysterectomy. The wound can be closed perfectly in vaginal hysterectomy as well as in celotomy and a drainage tube or gauze can be placed in properly. That women have a great assurance of disease not returning after a "pick-ax" removal of the uterus I deny. When Dr. Gross removed a cancer of the breast he removed all the glands and the adjacent glands so as not to leave any possibility of return. Operate in such a way that you will know what tissues or parts you are dealing with and just what organs or parts and how much to remove. I believe the Sims position is the proper position for vaginal hysterectomy. As lymphatics are so numerous in uterus, cancer of cervix is more apt to return than cancer of body of uterus. I think that with an early diagnosis cancer of uterus can be safely relieved by vaginal hysterectomy.

Discussion—Dr. Ward: I have had cases where the uterus had been completely destroyed and I removed it with my fingers and curette. It was like a rotten potato. The curette cannot remove the inner cells, so I cannot see how you can operate properly unless you go into the abdomen or else per vaginam, yet per vaginam you do not have the trouble that generally follows an incision through the abdomen. I do not agree with Dr Grant that vaginal hysterectomy is the safest by all means.

Dr. Sheldon: Have only one thought to add: Make the vagina thoroughly aseptic. Pack the vagina the night before with boroglyceride tampons as the bichlorid sometimes produces too much irritation.

Dr. Beatty: Cancer of uterus must be dealt with quickly. I think the general practitioners should learn to diagnose a cancer of the uterus early, and not wait until life is uncertain and early death sure. In reference to removing uterus per vaginam with fungoid degeneration of the endometruim, I think this is the only proper method.

Dr. Pearse: In a case of endometritis accompanied by double pyosalpinx upon hysterectomy with removal of sac and uterus, the symptoms of hysteria were exaggerated.

Dr. Eastman: No other author gives the Sims position for vaginal hysterectomy except myself, yet I must say that my results have been perfect. I am well pleased with Dr. Sheldon's remarks. Another point is bringing down the broad ligament and not the uterus. Why do the Frenchmen say drag down the uterus? Vaginal fixation and closure of wound. I find I cannot always close the wound. Dr Fairchild refers to one of the most important questions, as to where the reflex comes from. I have known the uterus to be removed for ill-treatment by a rude husband. It is hard to locate the cause and it is the first thing to seek. Our operative procedure needs everything supplemented with it, as massage, milk diet, washes, etc. We cannot save all the women, yet we must learn to diagnose early.

Remote Effects of Laceration of the Cervix and Perineum: J. W. Young, M.D., Bloomfield, Iowa.—No doubt you have been asked to see lacerations many months after their occurrence, and at the same time were troubled with generally impaired health. There is a class of symptoms that do not always appear until many months after the injury. If a woman be strong at the time of the injury she may get up, but after years have passed she may suffer. These open wounds easily admit germs, on account of the gates being left open and the tissues lie waiting for infection. Reflex action then sets in and other troubles soon arise. It seems that when one organ is partially destroyed it affects the function of some other organ. Then if these organs can be affected by reflex action we are apt to have almost any trouble as a result of unrepaired laceration.

Discussion—Dr. Eastman: Dr. Emmet refers to the fact that in some instances the closure of laceration does harm. There is a law laid down by Dr. Savage that I think is very good: A reason why laceration increases neuroses is on account of the loss of

the sexual function on the part of the female as well as the male.

Dr. Fairchild: It is largely the condition of the uterus, rather than the laceration, that cause these reflex troubles.

Dr. Beatty: Many unnecessary operations for laceration are carried out. The scar is no more there than on any other part of the body. If you have to operate be sure and deplete first, then you are ready for your operation and there is no danger of anything serious following.

Etiology of Malignant Growths: Geo. Halley, M.D., Kansas City, Mo.

Discussion—Dr. Summers: We have no proof that recent degeneration is a result of micro-organisms.

Dr. Fairchild: Malignant growths are not due to micro-organisms. Origin is that of embryonic cell matrix.

Dr. Eastman: I do not think fibroid growths are due to micro-organisms. In tracing the history of cases of malignant tumors, for a long time there is usually found a trauma or some irritation.

Dr. Pearse: I believe malignant diseases are curable as well as syphilis. No reason except we have not found the proper method. In sarcoma you may have a limited growth for years, then it will burst forth and it seems to come out all at once and it will be seen all over the patient. There is a certain element of immunity I have innoculated active portions of carcinoma in sheep and horses, but they did not grow. Could we engraft carcinoma and secure a growth, the serum of that animal would be of use in the cure of malignant growths in other animals.

Dr. Halley: Why do we find germs in the tumors? A mass which plays the part of a nucleus is inhabited by a micro organism. Kohnheims theory is true of benign growths but not of malignant growths. You can't infect without irritation.

Gastroraphy for Enteroptosis and Gastroptosis: Dr. J. E. Summers.

Discussion—Dr. Halley: I found one case in which I operated for cancer of stomach and found a great portion of the stomach in the pelvis. I simply closed the wound and let the man die.

Dr. Eastman: I have found the spleen as low as the pelvis bones would permit. I have a case of abdominal hernia where I suggested that it be closed up. In another case where there had been an abdominal section the patient can only sit in a chair and the abdomen comes down to her knees. Possibly some abdominal procedure would do good.

Dr. Grant: We are more likely to overlook the cause of this trouble. A balloon stomach means a partial paralysis of those parts and I don't believe any surgical measures will cure these patients. They need a tonic treatment. A systematic diet, cleaning out the stomach, etc., will do more good than any surgical procedure.

Dr. Summers: I wish to say that the cases mentioned were subjected to various treatments before operative procedures were made. I have had some experience along this line, and I think that after all other means fail I can cure by some operation, by perhaps folding in the stomach.

Senile Endometritis: S. E. Sheldon, M.D., Topeka, Kas.

Discussion—Dr. Hall: Thought simple dilation to establish drainage together with treatment outlined, was the best that could be given.

Dr. Anderson: I wish to add that the galvanic treatment with less curettment aids in a speedy cure.

Surgical Iodoformism: Dr. Basham, Neal, Kas.—There are few that question its use. It stops the growth of certain bacilli, yet increases the growth of others. There are three stages in the process of iodoformism which should play a part in our daily operations. Iodoformism sometimes comes when iodoform gauze has been used to pack the abdomen, fever sets in and grave results sometimes follow.

Discussion—Dr. Summers: Have had very severe results in the use of iodoform, and think it is an overrated drug.

Dr. Sutherland: Have quit the use of iodoform and substituted acetanilid, and get as good or better results.

Imperfections in Abdominal Diagnosis: Dr. B. B. Davis—A thorough report of the case from the family or previous physician would avoid many mistakes that occur simply from overlooking a single symptom that later on clears up the whole matter.

1. Great care in diagnosis.
2. Carefully work out symptoms of lesions.
3. Waive evidence as to whether to operate and when.

Discussion—Dr. Eastman: This paper leads us to know that we should know how to diagnose abdominal intricacies. It seems to me that in any case one or more weeks should be taken in order not to make any mistake, and decide whether to operate or not and when.

Dr. Hall: I do not believe there are very many men who can tell what is the condition of the abdomen until it is opened. It is my opinion that the majority of celotomies are simply exploratory and that the previous condition was not thoroughly understood.

Announcement.

E. B. Treat, Publisher, New York, has in press for issuance early in 1897, the "International Medical Annual;" being the fifteenth yearly issue of that well known one-volume reference work. The prospectus shows that the volume will be the result of the labors of upwards of forty physicians and surgeons, of international reputation, and will present the world's progress in medical science.

The publisher states that the kind reception accorded to the "Medical Annual" has rendered it possible for him to spare no expense in his production; while the editorial staff have devoted a large amount of time and labor in so condensing the literary matter, as to confine the volume within a reasonable size, without omitting facts of practical importance.

The value of the work will be greatly enhanced by the thoroughness of illustration, both colored plates and photographic reproductions in black and white will be used wherever helpful in elucidating the text.

"To those who need the condensed and well-arranged presentation of the medical advances of the past year—and this class must necessarily include all physicians—we heartily commend the 'International Medical Annual.'"

The volume will contain about 700 pages. The price will be the same as heretofore, $2.75. Full descriptive circulars will be sent upon application to the publisher.

Pharmacopœial Preparations of Digitalis.

Joseph W. England, Ph.G., in The Philadelphia Polyclinic.

The practice is followed by some thoughtless pharmacists of preparing the tincture and infusion of digitalis from the commercial fluid extract, by diluting it with certain proportions of alcohol and water to make the tincture, and of water to make the infusion. As the average pharmacist buys his fluid extract of digitalis from the large manufacturing houses, the latter, for obvious reasons, encourage the practice. The editor of the *Philadelphia Polyclinic*, having had sent to him, by one of these houses, a physician's sample of the fluid extract with directions for making the tincture or the infusion from it, has requested the writer to answer this query: "Will the commercial fluid extract of digitalis, on dilution with alcohol and water, and with water, yield a tincture or an infusion that is equal in therapeutic worth to the officially made preparations?"

Careful consideration of this question leads the writer to answer it in the negative. The commercial fluid extract of digitalis is a most variable product and, in view also of its small dose, a dangerous preparation. It is, largely, a concentrated hydro-alcoholic solution of certain proximate principles, or their decomposition products arising from the use of heat. Roger has clearly shown that the physiologic power of digitalis is very nota-

bly diminished by the heat of a water bath. Thus, a 5 per cent. maceration which was found to be toxic in doses of 0.05 grams, when reduced only 6.6 per cent., required 60 times the original amount to cause toxic results. As the pharmacopœial process for making digitalis fluid extract requires that a certain proportion of the percolate be evaporated down to a soft extract, and dissolved in the reserved portion, it may be readily seen how some of the active toxic principles are changed into non-toxic inactive ones, even if it is practically possible—which is very doubtful—to keep the temperature down to 122° F., as officially directed. Kobert goes so far as to claim that, in the making of the fluid extract, digitoxin is precipitated in an insoluble form, but this is probably not true of all processes.

The commercial fluid extract, after being made, is stored for a time, and then the supernatant clear solution is carefully decanted from the precipitated proximate principles, and sold. These principles most probably have therapeutic worth, and thus a certain measure of strength is lost.

But, apart from the question of the effect of heat on solutions of the proximate prinples of digitalis, there is another factor. The writer believes that the commercial fluid extracts are usually made from the German leaf, which costs about 10 cents a pound, rather than from the English leaf, which costs about 50 cents a pound, for the reason that the fluid extract can be bought, commercially, for 50 cents a pint. If the English leaf costs 50 cents a pound, and the necessary alcohol costs, as it probably does, about 20 or 25 cents, and skilled labor is employed, fluid extract of digitalis cannot be made from English leaf at 50 cents a pint.

Some years ago the writer had trial made in the wards of the Philadelphia Hosp tal of tinctures and infusions of digitalis made from the German leaf. Clinical results showed that while physiologic effects were obtainable, they were not comparable in uniformity with those had with preparations made from the English leaf, and the reason most probably was that the English leaf is a cultivated leaf, carefully freed from leaf-stalks before being marketed, and more uniform in chemical composition than the German leaf. Brœker has shown that while he found 1 per cent. of digitalin in the parenchyma of the leaf minus the stalk and nerves, he found in the latter only 20 per cent. of that amount. Hence the variation in strength of digitalis preparations made from the German leaf.

The claims of manufacturers for so-called "standardized" fluid extract of digitalis should be taken by physicians *cum grano salis*. Even with Schmiedeberg's and Killiani's masterly analyses of digitalis, the chemistry of the latter cannot be considered as settled; certainly no practicable process has yet been devised for standardizing the galenic preparations. In their fluid extracts some manufacturers arbitrarily fix *differing* percentages of extracts as their standard. But as the really valuable part of digitalis constitutes but a small and varying proportion of the extract, and may be absent altogether, standardization by extractive is a delusion and a snare.

Chemists generally are agreed that the therapeutically active constituents of digitalis are: Schmiedeberg's digitalin, almost insoluble in water; digitoxin, wholly insoluble in water; and digitonin and digitalein, both freely soluble in water. The fluid extract and tincture contain most probably all four principles, but in view of the dissimilarity of menstrua and process, *in different relative proportions*. Hence an official tincture cannot be made from the official fluid extract. The watery infusion, while containing digitonin and digitalin, contains but a trace, if any, of Schmiedeberg's digitalin, and is *wholly free* from digitoxin, which is irregular in absorption, and highly dangerous in physologic action. Hence the infusion is a far less poisonous preparation than the tincture and fluid extract, and can be given in a relatively small dose. The absurdity of hoping to get a correctly made tincture or infusion by dilution of the commercial fluid extract must be apparent.

While the average retail pharmacist buys and dispenses the commercial fluid extract

of digitalis, he generally makes the tincture himself from selected leaf, and often from the English cultivated leaf. As the tincture requires no heat in making, and precipitates no proximate principles on standing, physicians would do well to taboo the use of the fluid extract, and use the tincture in its place. Further, on exhibiting the tincture to obtain physiologic effect, its dose may be more gradually and safely increased than with the very small dosed fluid extracts.

There is no doubt that room exists for improvement in the official formulas for making digitalis preparations. There exists also a necessity for a deeper chemico-physiologic study of the relative activities of digitalis preparations made from both the German and the English leaf. But these are questions which cannot be entered into.

The Management of Pneumonia.

American Medico-Surgical Bulletin.

Dr. S. Baruch read a paper with this title at a meeting of the New York Academy of Medicine, December 3, 1896.

He said that in 1859 and 1862, when he was in the hospital, the teachings in regard to the treatment of pneumonia were distinctly antiphlogistic. In the first ten years of his practice, Hughes Bennett, and others, had endeavored to impress upon the profession the fact that pneumonia is a self limited disease. Later on came the antipyretic era, from which the profession had not yet quite emancipated itself. The student was no longer taught that the pneumonia patient dies of apnea, but of heart failure, and this is the specter which now stands constantly at the bedside. The view that pneumonia is an infectious disease whose chief lesion is in the lungs, is attaining wider recognition, and personally, he believed that croupous pneumonia is no more a lung disease than typhoid fever is a bowel disease. Until this doctrine had been unreservedly accepted, our management of pneumonia would not be what it should be. It was now believed that while cold and unconstitutional depression are predisposing factors, the presence of the Sternberg-Frænkel diplococcus in the chief etiological element. He believed that the dyspnea of pneumonia is rather an expression of a special toxemia than of the crippling of the lung, because the degree of dyspnea is not proportionate to the extent of the lesion in the lung. The chief point of attack in both pneumonia and typhoid fever was the nervous system, and this explained the well-known fact that the general symptoms do not properly represent the severity of the lesion in the lung. The crisis of pneumonia marks the termination of the life period of the diplococcus, although the lung remains for sometime afterward more or less consolidated. We had learned that the chief object in the treatment of typhoid fever is to increase the patient's power of resistance, but many had not yet learned this lesson in regard to the treatment of croupous pneumonia. Having learned the true principles of the Brandt method of treating typhoid fever he had for the first time felt that he had a real means of controlling this disease, and this had led him to study the effects of hydrotherapy in pneumonia. The late Dr. Leaming stated in his book, published in 1884, that he had learned by increasing experience that better results followed an expectant than an active plan of treatment in pneumonia. In hospital and private practice pneumonia was a most fatal disease, ranking in the board of health reports next to phthisis. In furthering the recovery of a person from pneumonia rest of both body and mind were very important, and the physician should ceaselessly combat the prejudice of the laity against proper ventilation of the sick room. The diet should be restricted to milk and farinaceous broths administered with precision at regular intervals in quantities of 4 to 6 oz. These patients should be stuffed with large quantities of concentrated food. He did not use stimulants nearly as freely as formerly when the old plan of treatment had been employed. He used but few medicines. At first he gave a calomel purge, morphia for occasional pain, and strychnia for failing heart. When the heart became

weak he gave strychnia, 1-20 to 1-10 grain, at short intervals. It was far superior to digitalis or brandy. Phenacetin was rarely required, but could be used occasionally with advantage. It had heen clearly established that the diplococcus was found most abundantly in the saliva, and was destroyed by feeble mercurial solutions. This might explain why the effect of calomel in pneumonia was so much more striking when allowed to dissolve slowly in the saliva. Leaming had reported a most remarkable change in the symptoms in very severe cases as a result of the calomel treatment, and this he had himself sometimes noted. Clinical observation had abundantly shown that in the acute infectious diseases an initial large dose of calomel was decidedly advantageous, rarely disturbing the stomach or causing serious purgation, even when diarrhea was already present.

If baths were employed in pneumonia, they should not be given for more than eight or ten minutes, and the temperature should be at first 95° F., and should be gradually reduced with each bath down to 85° F. The value of the full bath in the pneumonia of children had been clearly proved by very well known clinicians, but we had given up the use of the full bath in adults because the disturbance and agitation attendant upon such a bath tended to increase the local disturbance. If, however, the patient presented a distinct typhoid condition, he would not hesitate to resort to this measure for its powerful tonic effect. Cold compresses he had found very useful in pneumonia. They are made of three folds of linen, stitched together at the edges, and having slits corresponding to the axillæ, so that the compress could be wrapped around the patient snugly. Two such jackets, and two pieces of closely woven flannel, an inch wider, should be provided for each patient. The compress should be wrung almost dry out of water at a temperature of 60° F., laid upon the flannel, the two rolled up and then applied snugly to the patient's chest. These compresses should be changed every half hour or hour. A higher temperature than 60° F. might be used for the compresses if there were much jactitation or insomnia.

In his opinion, the indications in lobar pneumonia were:

1. To stimulate and invigorate the nervous centers.
2. To prevent heart failure.
3. To reduce temperature.
4. To remove the toxins.

It would be found that after a few compresses, the patient would be quieter, the respirations deeper, and the skin and kidneys would be acting more freely. As the cold compresses were applied there would be first a contraction of the cutaneous blood vessels, but this would be quickly followed by dilatation of these vessels, as shown by the redness of the skin. This was different from the action of poultices, which relaxed the vaso constrictors while the cold applications stimulated the vaso-dilators and caused dilatation with maintenance of the tone of the vessels. In this way the heart was relieved and the rapidity of the blood stream increased. The most important effect of cold applications in pneumonia was their stimulating action upon the nervous system and the toning up of the heart. We should cease to regard elevation of temperature as the cardinal symptoms for therapeutic attack in these acute diseases. Cold compresses reduce the temperature, not immediately, but slowly, so that it can be noticed from day to day. It would be found that there is a very gradual cooling process going on, owing to the skin being bathed in vapor. The compress must not be covered with oil-silk, for this would convert it into a poultice, and its object would be defeated. The elimination of toxins was promoted by the wet compress as by all hydrate applications. They cause increased alkalinity of the blood, and hence, increased phagocytosis. It was his custom to give the patient six ounces of water to drink every two hours, and it was remarkable how this increased the quantity of the urine. In cases so treated, he had found that only about 40 per cent. terminated by crisis. The reader of the paper emphasized especially the fact that detailed and specific directions must be given regarding the mode of using the

water applications in pneumonia. He said that he had not lost an uncomplicated case of croupous pneumonia in private practice since the adoption of this mode of treatment. It had been found that in 156 cases of pneumonia treated in the J. Hood Wright Memorial Hospital that the mortality had been reduced one-half since the adoption of this method by the whole staff.

Effect of Wearing Veils.

Casey A. Wood in Boston Medical and Surgical Journal.

Although we hear, and occasionally read, of the ill effects produced by veils upon the eyesight, very little has been done in the way of determining the exact degree of interference with vision which these ornamental and occasionally useful protectors bring about. The fact that the wearing of veils is productive of weak eyesight, headaches, and sometimes vertigo and nausea, is within the experience of every ophthalmologist. Not only are these effects produced by the eyestrain consequent upon the added efforts made by one or both eyes to see through or around an obstruction, but the irregular figuring on the veil itself, is in some instances, a source of annoyance. As in other cases of abuse, the burden rests heaviest upon the weakest eyes, and probably the reason why one encounters so comparatively few instances of asthenopia directly due to veil-wearing is that the embarassed eyes are able to overcome the additional strain where the vision is normal, the oculo-muscular system in proper equilibrium, and the general health good.

A dozen persons were selected for the purpose of demonstrating the extent to which veils of various kinds influenced the eyesight, and the results warrant the following conclusions:

Every description of veil affects more or less the ability to see distinctly, both at a distance and near at hand.

The most objectionable kind is the dotted veil, although the influence of this variety for evil is more marked in some samples than in others.

Other things being equal, in undotted and unfigured veils, vision is interfered with in direct proportion to the number of meshes to the square inch.

The texture of the veil plays an important part in the amount and kind of eye-strain produced by the veil; when the sides of the mesh are single, compact threads, the eye is embarassed very much less in its effort to distinguish objects than when double threads are employed.

The least objectionable veil is that without dots, sprays or other figures, but with large regular meshes made with single compact threads.

It is not a necessary consequent of the wearing of veils that eye symptoms should result, for a healthy eye in a healthy body resists the strain of an impediment to vision just as it does other deleterious agents; and it is only when from other causes the eyesight is weakened that the wearing of an objectionable veil proves immediately and obviously hurtful. I have noted many cases of headache and painful vision, as well as other ocular symptoms, produced by veil-wearing in persons whose eyes were not over-strong, and I believe this practice is one of the agents, not perhaps always recognized, and contribute to ocular discomfort; it is not the part of wisdom to compel the visual organs to overcome unnecessary obstacles in the effort to see.

It has been urged in the defense of veils, that they are often required for the protection of the face, to keep the hair in order or to retain the hat in place. If the happiness and comfort of members of the gentler sex are thus bound up in veil-wearing, they should at least give preference to those veils that do the least harm.

But what cause can be urged for that not uncommon offense, the attempt to *read* through this unnatural screen? And yet such exhibitions are of every day and every night occurrence in places of public resort—street cars, railway trains, churches, theaters, concert-halls, club-rooms, etc.—thus adding to the injury of defective distant vision the insult of eye-strain for near work.